Opdivo® (nivolumab) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

Specialty *(Check one):* ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Opdivo (nivolumab) Dose: _____ **Frequency:** _____

If used in combination with Yervoy (ipilimumab), please indicate the dosage and instructions for Yervoy (ipilimumab) (Please note: Separate form request for Yervoy (ipilimumab) is **NOT** needed if dosing and instructions are documented here): _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

Please list ***all*** additional medications that will be used as part of this treatment regimen (This includes supportive care agents such as anti-emetics, growth factors, etc.) A copy of the complete order may be submitted in lieu of listing out each treatment:

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

☐ Yes ☐ No Has the patient experienced disease progression while on programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Tecentriq (atezolizumab), Bavencio (avelumab), Imfinzi (durvalumab)]?

→ ☐ Yes ☐ No Is the requested drug prescribed as second-line or subsequent treatment for metastatic or unresectable melanoma?

→ ☐ Yes ☐ No Will the requested drug be used in combination with ipilimumab (Yervoy) following disease progression on single agent anti-PD-1 immunotherapy?

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☐ **Ampullary adenocarcinoma**
- ☐ Yes ☐ No Will the requested drug be used in combination with ipilimumab (Yervoy)?
- ☐ Yes ☐ No Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
- Please select the clinical setting in which the requested drug will be used:
- ☐ Progressive disease ☐ Unresectable disease ☐ Metastatic disease ☐ Other

☐ **Anal carcinoma**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Other
- What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment

☐ **Biliary Tract Cancer (Cholangiocarcinoma and Gallbladder Cancer)**
- ☐ Yes ☐ No Will the requested drug be used in combination with ipilimumab (Yervoy)?
- Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
- Please indicate the clinical setting in which the requested drug will be used: ☐ Unresectable gross residual (R2) disease ☐ Metastatic disease
- ☐ Resected gross residual (R2) disease ☐ Progressive disease ☐ Other
- ☐ Yes ☐ No ☐ Unknown Is the tumor mutation burden-high (TMB-H)?

☐ **Bladder cancer**
- What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment ☐ Adjuvant treatment
- Please indicate the regimen:
- ☐ As a single agent
  - → Please indicate the clinical setting in which the requested drug will be used: ☐ Locally advanced disease ☐ Metastatic disease ☐ Recurrent disease ☐ Persistent disease ☐ High risk of recurrence after undergoing resection ☐ Other
- ☐ In combination with gemcitabine and cisplatin for up to 6 cycles followed by nivolumab maintenance therapy
- ☐ Other

☐ **Bone cancer**
- ☐ Yes ☐ No Will the requested drug be used in combination with ipilimumab (Yervoy)?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Unresectable disease ☐ Other
- ☐ Yes ☐ No ☐ Unknown Is the tumor mutation burden-high (TMB-H) [≥10 mutations/megabase (mut/Mb)] tumors?
- ☐ Yes ☐ No Has the disease progressed following prior treatment?
- ☐ Yes ☐ No Are there satisfactory alternative treatment options available for the patient's disease?

☐ **Central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer**
- Please select the requested drug regimen:
- ☐ Single agent
  - → Please indicate the type of underlying cancer the patient has:
    - ☐ Melanoma
    - ☐ Non-small cell lung cancer
      - → ☐ Yes ☐ No ☐ Unknown Is the patient's disease positive for programmed death ligand 1 (PD-L1)?
    - ☐ Other
- ☐ In combination with ipilimumab (Yervoy)
  - → Please indicate the type of underlying cancer the patient has: ☐ Melanoma ☐ Non-small cell lung cancer ☐ Other
- ☐ Other

☐ **Cervical cancer**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Metastatic disease ☐ Other
- What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment
- ☐ Yes ☐ No ☐ Unknown Is the patient's disease positive for programmed death ligand 1 (PD-L1) (combined positive score [CPS] ≥1)?

☐ **Classical Hodgkin lymphoma (cHL)**
- Please indicate the clinical setting in which the requested drug will be used:
- ☐ Relapsed disease ☐ Progressive disease ☐ Refractory disease ☐ Other
- ☐ Yes ☐ No Will the requested drug be used as a single agent, in combination with brentuximab vedotin or in combination with ICE (ifosfamide, carboplatin, etoposide)?
  - → ☐ Single agent
    - → ☐ Yes ☐ No Is the disease refractory to at least three lines of prior therapy?
      - → Please indicate which of the following applies to the patient: ☐ The patient was heavily pretreated ☐ There was a decrease in cardiac function ☐ Other
      - What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment
  - ☐ In combination with brentuximab vedotin ☐ In combination with ICE (ifosfamide, carboplatin, etoposide)

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma)**
- ☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
- Please indicate the regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other

☐ **Cutaneous melanoma**
- Please select the requested drug regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) (4 doses of ipilimumab, followed by Opdivo as a single agent) ☐ Other
- Please indicate how the requested drug will be used: ☐ Treatment of metastatic disease ☐ Treatment of locally recurrent disease ☐ Treatment of unresectable disease
- ☐ Adjuvant treatment
  - → Please indicate the clinical setting in which the requested drug will be used:
    - ☐ Stage III to IV disease
      - → ☐ Yes ☐ No Will the requested drug be used following complete resection or no evidence of disease?
    - ☐ Stage IIB and IIC
      - → ☐ Yes ☐ No Will the requested drug be used following complete resection?
    - ☐ Other

☐ **Endometrial carcinoma**
- ☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Metastatic disease ☐ Other
- What is the place in therapy in which the requested drug will be used? ☐ First-line therapy ☐ Subsequent therapy

☐ **Esophageal and esophagogastric junction carcinoma**
- ☐ Yes ☐ No Will the requested drug be used as adjuvant treatment of completely resected esophageal or gastroesophageal junction cancer?
  - → Please select the clinical setting in which the requested drug will be used:
    - ☐ Patient is not a surgical candidate ☐ Unresectable locally advanced disease ☐ Recurrent disease ☐ Metastatic disease
      - → ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?
        - → Please indicate the requested regimen: ☐ In combination with ipilimumab (Yervoy) ☐ In combination with chemotherapy ☐ Other
    - ☐ Neoadjuvant treatment OR ☐ Perioperative treatment
      - → ☐ Yes ☐ No Will the requested drug be used to treat esophageal or esophagogastric junction adenocarcinoma?
      - ☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)?
      - ☐ Yes ☐ No Is the patient medically fit for surgery?
      - Please indicate the requested regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other
    - ☐ Other

☐ **Extranodal NK/T-cell lymphoma**
- Please select the clinical setting in which the requested drug will be used:
- ☐ Relapsed disease ☐ Refractory disease ☐ Other

☐ **Gastric cancer**
- Please select the clinical setting in which the requested drug will be used:
- ☐ Patient is not a surgical candidate ☐ Unresectable disease ☐ Recurrent disease ☐ Metastatic disease
  - → ☐ Yes ☐ No Will the requested drug be used in combination with ipilimumab (Yervoy) or chemotherapy?
- ☐ Neoadjuvant treatment OR ☐ Perioperative treatment
  - ☐ Yes ☐ No Will the requested drug be used to treat gastric adenocarcinoma?
  - ☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)
  - ☐ Yes ☐ No Is the patient medically fit for surgery?
  - Please indicate the requested regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other
- ☐ Other

☐ **Gestational Trophoblastic Neoplasia**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Is the disease resistant to multi-agent chemotherapy?
- Please select which of the following applies to the patient's disease:
- ☐ Intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor)
  - → Please select the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Progressive disease ☐ Other
- ☐ High-risk disease
- ☐ Other

Continued on next page

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Head and neck cancers**
Please select the clinical setting in which the requested drug will be used:
☐ Unresectable disease ☐ Recurrent disease ☐ Metastatic disease ☐ Persistent disease ☐ Other
Which of the following applies to the patient's disease?
☐ Non-nasopharyngeal cancer
☐ Nasopharyngeal cancer
→ ☐ Yes ☐ No Will the requested drug be used in combination with cisplatin and gemcitabine?

☐ **Hepatocellular carcinoma**
Please select the requested drug regimen: ☐ As a single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other

☐ **Kaposi sarcoma**
Please indicate the type: ☐ Classic Kaposi sarcoma ☐ Other
☐ Yes ☐ No Will the requested drug be used in combination with ipilimumab (Yervoy)?
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line therapy ☐ Subsequent treatment
Please select the clinical setting in which the requested drug will be used: ☐ Relapsed/refractory disease ☐ Other

☐ **Merkel Cell Carcinoma**
Please indicate the clinical setting in which the requested drug will be used:
☐ Node positive disease or ☐ Node negative locally advanced disease
→ ☐ Yes ☐ No Will the requested drug be used as neoadjuvant treatment?
☐ Yes ☐ No Will the requested drug be used as a single agent?
☐ Metastatic disease
☐ Unresectable disease ☐ Recurrent disease or ☐ Stage IV disease
→ ☐ Yes ☐ No Will the requested drug be used in combination with ipilimumab (Yervoy)?
☐ Other

☐ **Non-small cell lung cancer (NSCLC)**
Please indicate the clinical setting in which the requested drug will be used:
☐ Recurrent disease ☐ Advanced disease ☐ Metastatic disease ☐ Resectable disease ☐ Other
Please indicate the requested regimen:
☐ As a single agent
→ Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
☐ In a regimen containing ipilimumab (Yervoy)
→ ☐ Yes ☐ No ☐ Unknown Is the patient positive for any of the following: EGFR exon 19 deletions, L858R mutations or ALK rearrangements?
→ ☐ Yes ☐ No Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
☐ In combination with platinum-doublet chemotherapy (e.g., docetaxel and cisplatin)
→ ☐ Yes ☐ No Will the requested drug be used as neoadjuvant treatment?
☐ Other

☐ **Pediatric Diffuse High-Grade Gliomas**
Please indicate the clinical setting in which the requested drug will be used:
☐ As adjuvant treatment ☐ Recurrent disease ☐ Progressive disease ☐ Other
☐ Yes ☐ No Is the tumor hypermutant?

☐ **Pediatric primary mediastinal large B-Cell lymphoma**
Please indicate the requested regimen: ☐ As a single agent ☐ In combination with brentuximab vedotin (Adcetris) ☐ Other
Please indicate the clinical setting in which the requested drug will be used: ☐ Relapsed disease ☐ Refractory disease ☐ Other

☐ **Pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma**
What is the place in therapy in which the requested drug will be used? ☐ First-line therapy ☐ Subsequent therapy
Please select the requested drug regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other

☐ **Primary carcinoma of the urethra**
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment ☐ Adjuvant treatment
Please indicate the regimen:
☐ As a single agent
→ Please indicate the clinical setting in which the requested drug will be used:
☐ Recurrent disease ☐ Locally advanced disease ☐ Metastatic disease ☐ High risk of recurrence after undergoing resection ☐ Other
☐ In combination with gemcitabine and cisplatin for up to 6 cycles followed by nivolumab maintenance therapy
☐ Other

☐ **Renal cell carcinoma**
Please indicate patient's disease state: ☐ Relapsed disease ☐ Advanced disease ☐ Stage IV disease ☐ Other
Please select how the requested drug will be used:

Continued on next page.

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☐ Single agent
- ☐ Yes ☐ No Does the patient have documentation of predominant clear cell histology?
  - ☐ Yes ☐ No Does the patient have documentation of non-clear cell histology?
  - What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment

☐ In combination with ipilimumab (Yervoy) (4 doses of ipilimumab, followed by Opdivo as a single agent)
What is the patient's histology? ☐ Clear cell ☐ Non-clear cell

☐ In combination with cabozantinib

☐ Other

☐ **Small bowel adenocarcinoma**
Please identify the requested drug regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other
Please indicate the clinical setting in which the requested drug will be used: ☐ Advanced disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)?

☐ **Small Cell Lung Cancer**
Please select the clinical setting in which the requested drug will be used: ☐ Relapsed disease ☐ Progressive disease ☐ Other
What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment
☐ Yes ☐ No Will the requested drug be used as a single agent?

☐ **Soft Tissue Sarcoma**
Please indicate sarcoma type: ☐ Extremity/body wall sarcomas ☐ Head/neck sarcomas ☐ Retroperitoneal/intra-abdominal sarcomas
☐ Rhabdomyosarcoma ☐ Angiosarcoma ☐ Other
Please identify the requested drug regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other

☐ **Upper Genitourinary tract tumor or** ☐ **Urothelial carcinoma of the prostate**
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment ☐ Adjuvant treatment
Please indicate the regimen:
☐ As a single agent
- Please indicate the clinical setting in which the requested drug will be used: ☐ Locally advanced disease ☐ Metastatic disease ☐ High risk of recurrence after undergoing resection ☐ Other

☐ In combination with gemcitabine and cisplatin for up to 6 cycles followed by nivolumab maintenance therapy
- Which of the following applies to the patient's disease: ☐ Metastatic upper genitourinary (GU) tract tumors ☐ Metastatic urothelial carcinoma of the prostate ☐ Other

☐ Other

☐ **Uveal Melanoma**
Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Unresectable disease ☐ Other
Please identify the requested drug regimen: ☐ Single agent ☐ In combination with ipilimumab (Yervoy) ☐ Other

☐ **Vulvar cancer**
Please indicate the clinical setting in which the requested drug will be used:
☐ Advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Is the disease HPV-related?
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
☐ Yes ☐ No Will the requested drug be given as a single agent?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
- ☐ Yes ☐ No Is the patient continuing on a maintenance regimen that includes provider administered combination chemotherapy?
  - Please indicate the regimen:
    - ☐ Opdivo used in combination with Yervoy for non-small cell lung cancer (NSCLC)
    - ☐ Other, Please explain: _____
- ☐ Yes ☐ No Is the patient experiencing severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, conduction abnormalities)?
  - Please explain: _____

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☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
→ Please explain: _____

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
→ Please explain: _____

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
→ Please explain: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition:
- ☐ Cardiopulmonary: _____
- ☐ Respiratory: _____
- ☐ Renal: _____
- ☐ Other: _____

☐ Yes ☐ No Is the patient within the initial 6 months of starting therapy?
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

For cutaneous melanoma only:

☐ Yes ☐ No Is this request for adjuvant treatment of cutaneous melanoma?
→ Please provide the initial start date of requested drug adjuvant therapy: ____/____/____
How many continuous months of adjuvant treatment has the patient received? _____

☐ Yes ☐ No Is there evidence of disease recurrence or unacceptable toxicity on the current regimen?

For esophageal cancer and esophagogastric junction carcinoma:

Please indicate which of the following applies to the patient's disease:

☐ Esophageal squamous cell carcinoma in combination with ipilimumab
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

☐ Esophageal squamous cell carcinoma in combination with chemotherapy
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

☐ Unresectable advanced esophageal squamous cell carcinoma single agent treatment

☐ Recurrent esophageal squamous cell carcinoma single agent treatment

☐ Metastatic esophageal squamous cell carcinoma single agent treatment

☐ Resected esophageal cancer used as a single agent adjuvant treatment
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

☐ Resected esophagogastric junction cancer used as a single adjuvant agent treatment
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

☐ Esophagogastric junction cancer in combination with chemotherapy
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

☐ Esophageal adenocarcinoma in combination with chemotherapy
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

☐ Other

For gastric cancer only:

☐ Yes ☐ No Will the requested drug be used in combination with chemotherapy?
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

For non-small cell lung cancer and pleural mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma only:

☐ Yes ☐ No Will the requested drug be used in combination with Yervoy (ipilimumab) or in combination with platinum-doublet chemotherapy?
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

For renal cell carcinoma only:

☐ Yes ☐ No Will the requested drug be used in combination with cabozantinib?
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

For urothelial carcinoma only:

☐ Yes ☐ No Is this request for adjuvant treatment of urothelial carcinoma or the requested drug is used in combination with gemcitabine and cisplatin for up to 6 cycles followed by nivolumab maintenance therapy?
→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

The plan may request additional information or clarification, if needed, to evaluate requests.

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H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.